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REVALIDATING DOCTORS – ENSURING STANDARDS, SECURING THE FUTURE

Differences between assessment and appraisal

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Assessment and appraisal of doctors will soon be a part of our everyday working lives. We review what is meant by assessment and appraisal, setting them in the context of revalidation of medical registration and clinical governance.

Clinical governance is described as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.

Many of us have worked in clinical teams that strove for excellence, and others which, sadly, did not. In a good environment, ideas are invited from all sources, debated openly and respectfully, and joint decisions made based on the best evidence available. Appropriate support is given to those putting the ideas into practice, encouraging their professional growth.

If we are to achieve the aims set out for clinical governance and for revalidation, it is important that assessment and appraisal are used to support professional and personal development, and key differences between them are understood by all concerned.

ASSESSMENT involves comparing the subject's performance with a fixed standard that may be:

- the performance of other people (peer or norm referenced)
- a pre-specified set of criteria (criterion referenced)
- the assessor's expert understanding of the minimum required for safety (limen referenced)

Standards are set in different ways in different circumstances.

An interview for a consultant post is a peer referenced assessment. Candidates are judged against each other, and, although interviewers have a broad understanding

of the features to be assessed, it is difficult to define exactly how these are measured and compared between candidates.

ALS courses are criterion referenced. The criteria on which a pass or fail mark is given are clearly laid out. If candidates do 'A, B, C,' then they pass, and if they do other useful things but fail to do A, B, & C, they fail.

Limen referencing is the most frequently used assessment method in the professional world, and one we all use every day. We know that some trainees, some nurses and some colleagues are better than others at given tasks and roles. For instance, we might ask one trainee to talk to a patient's family and not another, even though both trainees are at the same grade, doing the same job. Explaining our underlying reasons for the choice; what the chosen trainee does, or does not do, is more complex. It is easier to say whether or not a trainee is competent at a complex task than to break down the task into its component parts, and assess these. This is particularly clear when someone is not functioning. Often, people know that a doctor is having difficulty, long before formal actions are taken. Limen referencing tells us something is wrong – the hard part is defining what this is, in terms that the 'doctor in difficulty' can understand and appreciate.

Doctors undergo many assessments during long years of training, and work hard to pass these. Like all candidates, our learning is influenced by what is assessed.

We want assessments of us to be reliable, valid, to appropriate standards, and achievable.

Knowledge and skill are easier to measure than attitude. However, in our world of work, we know that more problems are related to attitude and behaviour than to lack of knowledge and skill. So we need a method of reviewing progress and performance which encourages reflection on both performance and behaviour and helps individuals to plan their learning. This is the role of appraisal.

APPRAISAL can be defined as a two-way dialogue focusing on the individual's professional, educational and personal development needs, which produces agreed outcomes.

An assessor's role is to make a judgement about evidence presented, but an appraiser is there to explore the appraisee's interpretation of the information, to identify blind spots, to encourage reflection and help in identifying strengths and development needs. Evidence from the past is used in appraisal as a basis for discussion and planning. The content of the discussion is confidential, but at the end, the appraiser and appraisee produce an agreed statement that is made public. For instance, an appraisee might discuss the problems he or she is having as the consultants leading audit. The department might have two factions, one of which is not contributing to effective audit. The confidential discussion at the appraisal interview might identify the need for the appraisee to have more training in negotiating and influencing, whereas the public outcome would only identify an increased sessional commitment to audit in the consultant's job plan.

It is important that both parties know who will see the statement, and what purpose it will serve within the organisation. Management will need to agree proposed changes in job plans, and requirements for study leave. Decisions about personal effectiveness and time management may be more appropriately retained privately in one's portfolio.

If one's appraisal is done by the line manager (clinical director) it may be harder to raise concerns about organisational issues that effect performance, for which the clinical director has organisation responsibility. Thus, discussions are more likely to be open and wide ranging, if the appraiser is not the clinical director. On the other hand, an appraisal with the clinical director is more likely to lead to changes

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